

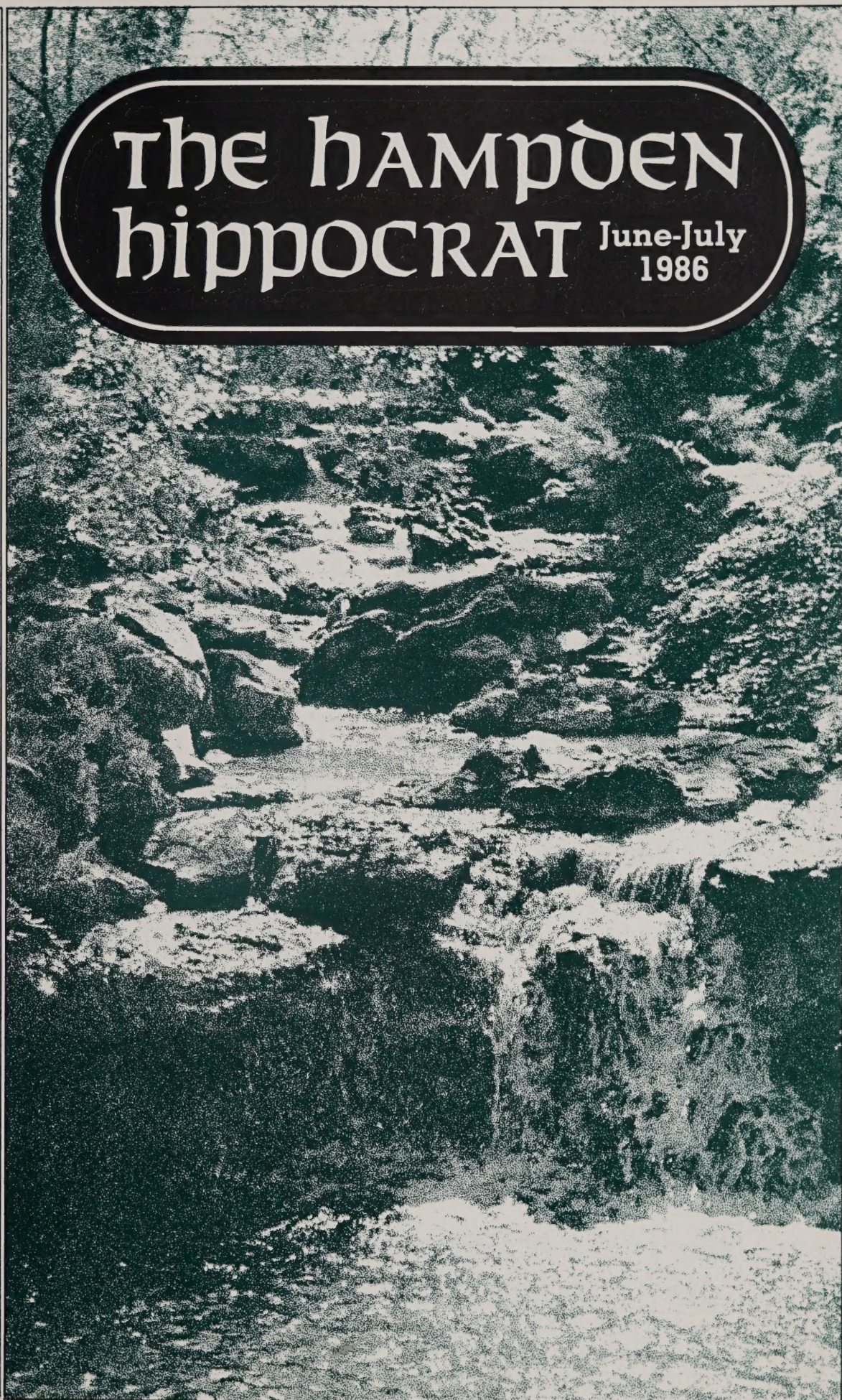
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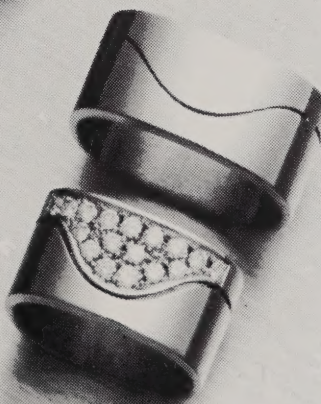




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THE HAMPDEN HIPPOCRAT

VOLUME XXXXII NO. 10
JUNE — JULY 1986

1414 STATE STREET
SPRINGFIELD, MASSACHUSETTS 01109
Telephone: 736-0661



THE HAMPDEN HIPPOCRAT is published
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JUNE — JULY 1986

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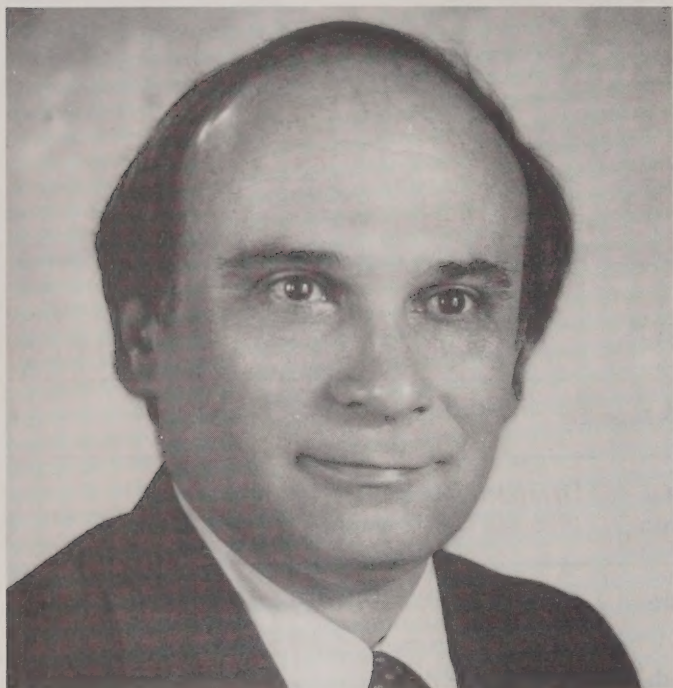
THE HAMPDEN HIPPOCRAT is published bi monthly.

The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated.

All communications should be addressed to Carol L. Nystrom, Hampden District Medical Society, 1414 State St., Springfield, Mass. 01109; Telephone: 736-0661.

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HDMS President's Message



Gregory A. Slachta, M.D.

"May you live in interesting times," the Chinese Proverb says, and indeed we do live in interesting times. We live in an era that begs analysis of the most schizophrenic nature, an era where the federal Justice Department system has declared a laissez-faire attitude in the antitrust arena for the exception of medicine. Antitrust has been a lucrative field of legal endeavor for the legal profession in the health care system. It is an era that cries for medical perfection in the delivery of care from society through a runaway tort system, expensive Peer Review Organizations and "beefing up" Boards of Discipline. Yet, it also undermines the quality of care through paraprofessional delivery allowing diagnostic and therapeutic medical care to be delivered with far less scrutiny of credentialing and "quality assessment" than required of the medical profession. The federal and state governments have made medicine "cost driven" in a consumer oriented marketplace belying the impossibility of keeping our society healthy at the current reimbursement levels without smothering regulation. At the same time it fosters a national direction of deregulation as a means of bringing cost down (airlines, trucking). Government promises to take care of its elderly through Medicare and Social Security and its poor, through Medicaid and benefit programs, but fails to fund or accept the responsibility of the inadequate funding.

Why do we live in such a schizophrenic era? Why has medicine been singled out by government to stand as a whipping boy for the national flagellation? Has our profession failed to provide the country with the quality care it deserves? No, the care is measurably better. Has our profession failed to distribute this care? No, access has never been higher. Have we become less dedicated to our profession? No, we, as a profession, are more dedicated than ever, even under the stress of the national and state governments' underminings? Where have we gone wrong? What did we do wrong? Nothing and everything. It is just this dedication and self-induced perfection that has led us to where we are today. While we worked and cared, we believed there were no forces out there that would dare attempt to undermine the principles to which we dedicated our lives. So, like the bear that hibernates, we settled down to a long winter's nap. Our nap has been rudely interrupted. A foolish intruder has entered the cave as a false advocate of the medical care to the population. He is the businessman, the insurance man, the legislator and the regulator. His message to the people is schizophrenic and presently not understood by them. He is a fraudulent advocate of quality access.

We can and will change the course. It is the wrong course for our children and our children's children. We must do it by participation in the community, the political process and through organized medicine. Presently, there is less divisiveness in the coalition of physicians than there has ever been.

We must learn to make this coalition of medical specialists, surgical specialists, obstetricians, salaried and private practitioners act in consort to shape the future of our community, state and nation. Begin by joining the state and district society. Join the AMA.

That, however, is not enough. Spend time educating yourself to understand the forces working against us. Participate in their activities. They will be directed to community service and political awareness and accountability. They will be directed to economic awareness and education. Be involved. No one individual or small group of individuals can evict the intruder. Only a united front and active participation can change things. Join us.

"The people who get on in this world are the people who get up and look for the circumstances they want, and if they can't find them, make them"

George Bernard Shaw

Woe is he who disturbs a sleeping bear!

Annual Meeting of the Hampden District Medical Society April 21, 1986

The featured speaker at the Annual Meeting of the Hampden District Medical Society on April 21, 1986, was Erik N. Burkowitz, Ph.D., Professor and Head of the Marketing Department, School of Management, University of Massachusetts. Prof. Burkowitz is an accomplished speaker who used the techniques of over statement and exaggerated scenarios to keep the attention of his audience and make his profits.

Aggressive marketing of health care is a fact of life in many parts of the country and it is only a matter of time before it hits Massachusetts. Young doctors in particular, he felt, should recognize this and plan accordingly. The conflicts of marketing and advertising frequently conflict with what has been viewed as ethical behavior on the part of physicians. However, doctors should recognize that ethical behavior is viewed differently by different groups. Whereas aggressive competition may be abhorrent to some physicians, many business managers thrive on driving their competition into bankruptcy. In fact, this may be their goal. As more and more business managers enter the field of health care, marketing will become more aggressive.

The results of the high cost of health care and the signs of competition it brings are already evident. Hospital beds are going unfilled in many parts of the country. Some large health care organizations are hiring doctors at very low salaries. In many circumstances and areas it will be a question of Big vs. Little as to who survives. The quality of health care is no longer a criterion according to Prof. Burkowitz as the assumption is made that everybody gives quality health care. The efficiency and cost of the health care will be the hallmark of the successful medical practitioner, at least as seen through the eyes of this management expert.

Doctors do best what they are professionally trained for and few have had the time to be sufficiently trained as managers. Thus, they continue to run sizeable businesses, depending on personnel, with only a high school bookkeeping background. In this changing environment, Prof. Burkowitz feels that doctors need to hire professional managers.

To make his point more vivid to his audience Prof. Burkowitz announced that he would soon be taking a job as Health Director for Sears and Roebuck. He described the scenario where Sears and Roebuck stores would have health care centers in malls in which they would use the regular marketing techniques of malls to draw patients to their health care centers and use the patients' waiting time at the health care center to stimulate them to shop at the malls. He described a system where, unlike local HMO's which give only local medical coverage, Sears Premium Health Care Plan would offer health care coverage in every store where the participants receiving care would have their medical histories banked in the Sears computer system where any doctor working for them could bring it up at a moment's notice. Thus, the patient vacationing in Denver could be treated just as well there as at the store in Ingleside and pay for the medical bills with their new Sear's Discovery Cards. As he put his audience into shock with the scenario of big business competition, he had made his points well and announced that the whole scenario was really fictional.

Prof. Burkowitz's message was that complacency is dangerous, that the medical profession should be professionally managed and must look at other businesses to see what techniques in management and marketing it can best apply.

Terry D. Ryan, M.D.

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The Fireman's Dilemma

Through a cruel twist of fate, Paul Brophy's master DNA instructions encoded an error. The lamination instructions for his delicate cerebral communicating artery failed and forever embedded a weak link in the fireman's vascular system. Just beyond his fortieth year of life Brophy's frayed cerebral artery exploded, squeezing his brain, his motor strip, his cherished memories, his lust, his love. Paul Brophy's passions evaporated within the muderous constiction of his cranium.

Forever, the fireman was dead, vegetative.

The case was labeled clean, a test case. The feeding tube would be removed at the family's request. All parties agreed—his loved ones, their legal counsel, and their priest advisor. And to avoid hospital objection, to avoid his doctor's understandable misgivings, Brophy might well have been transferred from the Stoughton hospital where he lay in a coma. Stop all extra-ordinary care, said the family. Permit Paul to slip to a lingering memory.

Passive euthanasia, cried the press, Loss of life...?

Christianity and Judaism reject the willful taking of human life. Unless, of course, it occurs in the act of holy combat. To preserve one's belief system, all rules of conduct are permissibly shattered. Does this mean, in dealing with the vegetable state, we possess no guidelines for our behavior? If we believe we must not tamper with the holy human temple, must not forshorten one moment of life, even if life means non-sapience, or worse, unbearable agony, then why manipulate human physiology in the name of CARING in the first place?

Brophy sits between a number of extremes. Arguments swirl like muddied water over the case of infant Baby Jane Doe; the murky current sweeps past the elderly (four aged men killed their wives in Orange County, California since July, 1985). Mercy killing? Age as an isolated factor seems not to matter. Perhaps a mute vitality still exists in Paul Brophy's limpid form. Perhaps it exists in the minds of the hospital staff who knew him before his flesh melted in the furnaces of his misdirected metabolism, a vitality stalling rational minds with indecision.

Extremes also involve the basic concept of humanity. On the one hand stands the inviolate sanctity of life doctrine, extolled in the extreme by Rabbi Moshe Tendler, who insists, "Life is of infinite worth and a piece of infinity is infinity. A

minute of life is as valuable as a hundred years of life." Echoing a countercry, the Hemlock Society insists the suffering have a right to die, to accept the physician's mortal nostrum, though it be a pharmacologic death knell. And, between these polar views come mainline Protestants, less traditional Jews, and many Roman Catholics who accept the concept of withdrawing life-support therapies but not outright active euthanasia. Off to one side, Christian Scientists reject medicine's scientific chalice and refuse mercy killing—active or passive—with pious perserverence.

A nasogastric tube is not a chalice. A chemically-defined liquid diet bears no resemblance to blessed holy water. Artificial intravenous fluid replacement, started shortly after Paul Brophy's brain exploded, aimed his doctors down the road of science, picking up the necessary technology along the way. His doctors acted as humans. Physicians, not God.

At that moment, Brophy's doctors set the stage for indecision. Suppose the cards had been dealt differently. Suppose Brophy had been left paralysed, yet aware of his predicament. Suppose he had elected to starve himself to death, yanking out the feeding jejunostomy repeatedly with what limited movement remained in one arm. Refusing all succor, immobile, yet sentient, would Judge Kopelman have rushed in with judicial robes swishing and insist the hospital force feed the fireman?

Bombast, laced with the eloquence of fear has woven a web of confusion about the issue of merciful death for victims of the vegetative state. By tapping into the collective guilt of our belief systems we attempt to forstall our tumble to eternity, to slow our inexorable, biologically pre-determined demise. With all of the cerebral ingenuity of our species we smear the crystal lens of reason with the grease of dread. We have converted a rational plan of action for the management of the brain-injured into a peripatetic conversation with our Gods.

Of course, Judge Kopelman never stood entirely alone. Other confused thinkers supported his position. Andre Wynen, Secretary General of the World Medical Association and a French Socialist, sounded a warning that passive euthanasia might become the solution for cost containment. Apparently, it is not permitted to ask how much longer we can support the ten thousand-odd vegetative souls in this country. The Massachusetts court held that "One can never

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consider the quality of life of the patient but only the quality of the treatment." Think about that one. Continuing to justify its position, to the court explained that the gravity drip of nutrients was no burden to Brophy, so why stop it? Had he developed his dead brain from a fall from a ladder and had he become impaled on a fencepost which penetrated his thigh but was "no burden to him", that is, no threat, would the court recommend he be placed in a chronic care facility with a section of picket fence in bed with him? Although not the real culprit, confusion is part of the problem.

This isn't surprising in light of man's social history, past and most recent, where justice and truth fade before the boisterous where we call politics. America's John Wayne tunnel view of courage, the sword rattling response to perceived threat, understood only by the brainstem, evokes a national warrior's reply. Blood is spilled, honor defended. And while we erect marble statutes in the name of our fallen soldiers, what wall in Washington stretches out of the bowels of the earth in memory of our civilian dead?

There seems to be no place in our psyche for the quiet, humble courage, the sort of stubborn singlemindedness that resolves a man to say, "Turn off the machine. It's time to stop all this nonsense."

Some of our civilian dead remain in respirators; others linger in silence with a feeding pump overhead rather than a headstone. Instead of removing them from the hospital ramparts, we mock their dignity with plastic tubes and caloric slop which merely wrestles them from death momentarily, sustaining their shrunken carcasses. Have our civilian "living" dead not earned a place in the eternity of memory?

Versed in emergency care techniques, Paul Brophy understood the nuances between death and vegetative life. So clear was his vision of the senselessness of prolonging support for a brain dead victim that he expressed his wish to never be kept alive by artificial means should he ever suffer a sublethal brain insult—the very pathologic dish served up by the chefs of fate in April, 1983. Indeed, the fireman had witnessed the anguish brought on by the vegetative state.

What remains problematic is this: Judge Kopelman was not without ammunition. For, to date the legal record reads, in part:

Quinlan: discontinuing a respirator is a medical not a legal decision and is acceptable.

Saikewicz: substituted judgement is alright; everyone in Brophy's case had already decided, unanimously.

Dinnerstein: do not resuscitate orders may be arranged in advance; this sets the stage for a compassionate death.

Recently, the American Medical Association's Council on Ethical and Judicial Affairs has gone on record supporting the withdrawal of life-sustaining therapies—including the withholding of food and water—thus, supporting physicians who wish to stop life-support for coma patients.

In the final analysis, our duty as physicians pivots upon two time-honored principles: to meet the standards of professional care considered to be the state of the art; and secondly, to comply with the wishes of the family. Brophy's dilemma is a contradiction in terms, for his case met these criteria. Only one element was missing in the discharge of the case.

Courage.

Judge Kopelman demured (when presented with the family's request), "I would rather err on the side of caution."

Kopelman's decision indicates he could not make a

relatively straightforward decision given an extra-ordinary amount of time to deliberate—that is, by clinical practice standards. Many doctors make similar judgements on a weekly basis in busy intensive care units. With the blessing of the family, with at least three prior cases to support him, with the backing of John Paris, a Jesuit priest, with the approval of the family's lawyer, the judge staggered beneath his responsibility. Ultimately, he failed.

For the physician, the final common pathway to therapeutic failure is cardiopulmonary collapse, renal shutdown, and brain failure. Beyond steroids—the pharmacologic last rites—and antibiotics and drainage and packing and splinting and soothing, lies the intrepid territory of critical care medicine. Not so much honed and shaped out of the substance of modern practice, intensive care appeared as an accident of birth. Physicians edged down the path of extreme care, wrestling for the survival of handfuls of vital cells, specific organs, winning the physiologic war until, unexpectedly, we turned one corner too many and came face-to-face with our own frailty, our transience.

Unfortunately, as doctors as well as members of the human race, we haven't prepared ourselves and we cannot believe that we have painted ourselves into a corner on the vast uncontrollable canvas of our universe. We toy with our belief systems, our open-ended conviction that there is no end to anything. If there is truly a heaven then why hold our loved ones in this hell we call chronic care rather than jettison them to eternity?

If it is true that we must stop behaving like children, we must then act with courage and take charge of our profession without a crippling fear of litigation. The winds of change are blowing softly. Man invented the feeding tube and a man, not God, must remove it if the provision of food and water becomes senseless. To cringe behind our dieties returns physicians to hiding behind a shaman's mask.

There must be a certain grace within our souls which will speak out for the good death. If not and if life is truly worth a fragment of eternity, then we must all be prepared to become paupers in the name of unbridled humanity.

David W. Page, M.D.



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Conversations With A Wizard

When all the world seems to be insane, I go visit Hornbeam, and he in turn has an uncanny knack of knowing when I need to talk to him. Somehow his ageless wisdom is a comfort in the soup of materialism in which we live.

The air was warm, yet the trees were incongruously leafless as we picked our way to his favorite corner of the woods. Shadow wandered off, investigating with avid attention and then marking, a stump that to my paltry senses seemed no more than that.

I waited patiently perched on a log, then as the sun dipped lower and the shadows lengthened, I spotted his star studded cape through the winter bare trees as he strode crackling through the dry underbrush.

"Hail and well met," he beamed, resting on a foot on my log.

"Welcome," I intoned, not wanting to dampen his enthusiasm, but unable to muster reciprocal cheeriness.

"Trouble?" he frowned, arching a knowing eyebrow.

"You could say that," glumly.

"Well, spill de beans," he said, with a malicious glint in his eye.

He knows full well that I hate it when he shares in the corruption of what was once the Queens English, but as I scowled at him, he put a conciliatory hand on my arm and sat down next to me. Then he slid his hat to the back of his head, rested his chin on the heel of his hand and looked at me expectantly.

"You know," I said, "we've known each other for a while now - -"

"A mere blink of an eye in the natural scheme of things," he said, shading his eyes as he gazed whistfully at the setting sun.

I felt very small in the wake of his years, and images of the time clock of the universe flashed across my mind. Mankind's (sorry, Personkind's) troubles were really rather small and transitory, and mine were even more miniscule.

Nevertheless, I steeled myself, gritted my teeth and said, "The Pettifoggers have been at it again."

"The Pettifoggers or your peers?"

How did he know? Damn it, he always does this! I never cease to be amazed how this simple savant from the woods can home in like a hawk to the kill on anything I bring up.

"The Pettifoggers egg the peers to the Pettifoggers profit." Pretty neat alliteration that, I thought smugly.

"Well?" He waited, unimpressed.

"A psychic, a seer she claims, had a test on her head and now alleges that since then she can't foretell things the way she used to."

"I've seen that before too. It's one way out for them. There was this crazy old bat once, told King John that the Barons weren't serious at Runnymede, and you know what happened there. She blamed some old wizard who had it in for her," —I swear he actually looked guilty — "said he'd put a spell on her cat. Ridiculous of course!"

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This was the first time that I'd ever heard Hornbeam make reference to an event that I could date, but now was not the time to puzzle this out, so I filed it away for future cogitation.

"So, did anyone believe her?"

"Hah! Not likely. She was last seen trying to sweet-talk her besom into some semblance of flight."

"This one got \$980,000!"

I never believed the cartoon strips where characters have dollar signs in their eyes, but that afternoon my unmaterialist friend got pretty close. After a long pause, he said, "Well, she certainly saw that one coming, didn't she. There wasn't anything wrong with her precognition that day, that's for sure." He sat and pondered a while more, then asked "What's happening to your problems with Mal Practice?"

"Not much. Everyone's aware of the problem, but no one can agree what to do, especially since those who make the decisions and the laws are the Pettifoggers themselves. The Coney Island roller-coaster is silent for lack of insurance, Newport Beach got sued for several millions for not warning a surfer that he could fall off his surfboard, bars are held liable for letting drunks get drunk."

"Inn surance?" he chuckled.

I ignored him.

"What can I tell you? Medicine is probably most critical since there are now women who can't find an Obstetrician to deliver their babies, and a hell of a lot of good Doctors are taking off for places where the malpractice rates are reasonable. People still don't understand that these ridiculous rates and even more ludicrous awards come out of their pockets in the long run. The problem in this state is compounded by the restrictive reimbursement system imposed on us."

Hornbeam's eyes were glazed at the onslaught of this litany of misery, but true to his role as confessor he squared his shoulder and waited. "Well, get on with it," he prodded at last.

"At least a couple of good things happened since we talked last," I said. "A pair of dictators who ripped off millions of our tax dollars got kicked out. The only trouble is that they salted so much away that they're still living high off the hog. Yet the whole scene is just symbolic of the incredible waste that is so rampant, like paying \$3000 for a hammer!" Finally I ran out of steam. He'd heard all these examples of flagrant fiscal mismanagement before.

Hornbeam sat and pondered. "In my day," he said at last, "things were admittedly a lot simpler. We had a few tyrants certainly, old King John was no angel as you know, but one

thing was different—people dealt with people. If I magic someone they pay me as best they can, I don't expect some other person to step in and pay. If they don't like what I do, they tell me, they don't run to the Pettifoggers. I think if you people had to deal with each other instead of some anonymous third, fourth or fifth parties that things would be a lot different and a lot more civilized."

"As for the tyrants and wasting your money—we never used to pay any tributes to anyone. If we wanted to help a country we made it a colony, then we went in, took over and taught them the right way to do things. Didn't you tell me your government did that recently?"

Seeing I was not going to rise to the bait, he stood up and straightened his hat and cape. "The offer is still open, you know. Even you could learn to do some magic."

I was still tempted.

Nicholas P.W. Coe, M.D.

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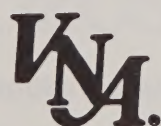
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Letter to the Editor

The Department of Public Welfare's Medicaid Second Surgical Opinion Program has been awarded to HealthPro, Inc. as of February 19, 1986. This mandatory program requires that Medicaid recipients in Massachusetts seek a second surgical opinion consultation from a Board certified or Board eligible physician for a selected list of surgical procedures. The program covers the following ten procedures: Tonsillectomy/Adenoidectomy; Hemorrhoidectomy; Excision of Varicose Veins; Sub-mucosal Resection; Spinal Fusion; Disc Surgery; Hernia Repair (age 5 or older); Hysterectomy; Coronary Bypass; and Meniscectomy.

HealthPro, a Worcester-based physician peer review organization (formerly the Central Massachusetts Professional Standards Review Organization) has been involved in health care cost containment and quality assurance for the Department of Public Welfare and private industry for over ten years. The HealthPro Board of Trustees, a governing body of 15 physicians representing a cross-section of specialties, has

authorized this agreement because of their strong commitment to peer review. The professional staff of HealthPro includes physician consultants from all specialties, highly trained utilization review nurses, health administrators, medical records professionals, and technical specialists. HealthPro also maintains a strong commitment to physician education. Massachusetts physicians are being offered a variety of educational programs designed to promote cost-effective utilization of health services in the acute care setting. The funds for such programs are made possible through the National Fund for Medical Education (NFME).

HealthPro welcomes the participation of members of the Hampden District Medical Society in the statewide Medicaid Second Surgical Opinion Program. We need your support to ensure that the program remains under the aegis of a physician organization. Physicians interested in joining our consultant panel are urged to contact Mrs. Julie Seiler, R.N. at HealthPro, Inc. (617) 757-5440.

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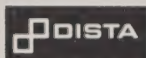
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The 'Myths' and the 'Facts' of Medical Malpractice

On March 24, 1986, Massachusetts Lawyers Weekly published a front page article entitled "Latest Medical Malpractice Bill Riles Lawyers" and ran a "fact sheet" on the medical malpractice issue on its MBA page.

It seems to me, as president of the Massachusetts Medical Society, that those articles reflect an unwillingness on the part of the organized bar to confront the entire medical malpractice issue.

Attorneys Esdaile and Smith both recognize that physician income is largely capped as a result of recent legislation that prevents doctors from passing increases in their overhead costs through to either patients or their insurers. This situation, unique to Massachusetts, has indeed contributed to the problem that we face.

While the inability of physicians to pass through increases in the cost of malpractice insurance is an important issue, it by no means is the only issue. The organized bar refuses to acknowledge the magnitude of the increases in the cost of malpractice insurance and the role played by the common law tort system in those increases.

This refusal to acknowledge the full extent of the medical malpractice problem is evidenced in the MBA's "fact sheet," which seems designed to generate more heat than light. I believe that the readers of Massachusetts Lawyers Weekly would be interested in a physician's view of medical malpractice myths and facts, which I present (see the text below) in the same format as that of the MBA Action Committee on Medical Malpractice.

There is a growing consensus that serious dislocations in the liability insurance industry are largely a product of excess in the common law tort system. Recognition of the full scope of the problem is a necessary step towards its solution.

Myth: 1. M.D.'s are not victims of frivolous suits.

Fact: In 1983, in 57% of the cases where the tribunal found there was no legitimate question of liability appropriate for judicial inquiry and the result was merely an unfortunate medical result, plaintiffs nonetheless proceeded to file bonds, often at reduced levels. More than 1/2 of the cases deemed by

the tribunal to be frivolous in 1983 proceeded beyond the tribunal level. This perhaps explains why defendants prevail in 71% (to use the MBA's figure) of the medical malpractice case tried to a jury verdict. A significant number of cases are also settled at costs below the cost of trying a case to a successful conclusion. But doctors are not the only victims of these unfounded suits; all consumers pay the costs generated by these meritless claims.

Myth: 2. Settlements and jury awards are not out of control.

Fact: Jury verdicts in excess of \$1 million have become increasingly common in all areas of medicine. In the month of February 1985, there were at least six medical malpractice cases reported in the Lawyer's Weekly as settled or tried to a verdict in which the resolution of the case cost \$350,000 or more. In three of these cases, the cost of resolution exceeded 3/4 of a million dollars. In April 1985, there were two cases resolved for a combined total of \$3,394,000. Verdicts in excess of one million dollars exceed the level of available liability insurance coverage for physicians and place great pressure on insurers to settle cases within policy limits, despite the insured physician's feeling that there was no malpractice. The estimated average loss per claim closed with indemnity payment increased from \$91,229 for claims reported in the first half of 1979 to \$219,455 for claims reported in the first half of 1983, an increase of 140% in four years (equivalent to an annual increase of 25% per year)* (*Source: 1984 JUA rate filing and JUA charges for increased limits coverage.)

Myth: 3: The premiums paid to the JUA have created a surplus of assets and current rate increases are unjustified. Therefore, no tort reform is required.

Fact: The JUA is a non-profit organization that is regulated by the State. Rates are established by the Commissioner after adversarial hearings before the Insurance Commissioner. The Massachusetts Medical society, which is interested in avoiding over-charges to its members, and the State Rating Bureau, a non-partisan organization, contribute data and actuarial

Continued on next page

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The 'Myths' and the 'Facts' of Medical Malpractice

Continued from previous page

evaluation of that data in addition to the JUA's submission to the State Insurance Commissioner. In the ten years the JUA has been in existence, no private insurance company has elected to offer insurance in Massachusetts at the rates established by the Insurance Commissioner. If the JUA was able to amass a pot of gold from premiums during that period of time, it is only logical that profit oriented insurance companies would be competing for that money. No actuarial analysis of the JUA's assets has concluded that a surplus exists.

The assets accumulated by the JUA are there primarily to assure that awards to injured patients represented by the MBA members are paid. The MBA should be concerned that the JUA has sufficient assets to pay legitimate claims.

The need to accumulate assets is clear from a New York State example. In its last year of insuring doctors in New York State (1974), Employers of Waussau collected \$38 million in premiums. Even though it collected no additional premiums, it has paid \$372 million in claims and defense costs since 1974 and has reserved an additional \$68 million for pending claims resulting from business it stopped writing more than ten years ago.

Myth: 4. Only a few doctors will have premium costs for the 1985/86 over \$4,900.00.

Fact: Fully twenty percent of the physicians insured by the JUA are in high-risk surgical specialties and have paid between \$9,600 and \$15,300 (depending upon specialty and rate group) for medical malpractice insurance during each of rate years 1983-84, 1984-85, 1985-86. Under the rate decision issued last December, those same doctors face retroactive increases for those years totalling between \$19,700 and \$31,500 in addition to amounts already paid.

It appears that those retroactive increases will not become payable until rate year 1986-87, which begins on July 1, 1986. In that case, general surgeons will pay \$36,500, OB-GYN specialists will pay \$51,800, and orthopedic surgeons will pay \$58,400 during the upcoming rate year, even if the rates remain at the level set in the December 1985 rate decision.

There is, however, every reason to expect costs to climb much higher during 1986-87 due to further large rate increases (including additional retroactive increases) that are certain to be granted by the Insurance Commissioner unless

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there is fundamental legislative change. The medical profession cannot survive without a comprehensive solution to what is indeed a medical malpractice insurance crisis.

Myth: 5. Doctors pay less as a percentage of their gross income for insurance than taxi drivers do.

Fact: The statistics frequently cited by opponents of Tort Reform Legislation do not take into account the recent dramatic increase in the cost of insurance to physicians. The comparison, whether true or false, is irrelevant. Taxi drivers pay insurance premiums which are high compared to other automobile insurance premiums. Taxi drivers have had that problem for many years. The rapid escalation in professional liability costs for physicians is a major part of the problem. In 1983/84, the highest risk group consisting of approximately 6% of the physicians in Massachusetts paid no more than \$15,300 for basic professional liability insurance. Today, nearly 25% of the physicians in Massachusetts will be asked to pay \$25,000 or more for malpractice insurance in 1985/86.

Myth: 6. There isn't a medical malpractice crisis in Massachusetts, only an economic crisis for doctors.

Fact: The cost of professional liability insurance for doctors does create a serious economic burden on them because of their inability to pass along cost increases to their patients because of the so-called "bans on balance billings" that are unique to Massachusetts. Even if this were not the case, there would still be a medical malpractice crisis facing consumers who would have to pay the ever escalating costs of those

premiums. And this crisis is not limited to the field of medicine. As Time Magazine recently stated in its March 24, 1986 issue on insurance in America, each of us . . . "are running into an obstacle far harder to surmount than high taxes and interest rates in (our) pursuit of the American dream. Liability insurance has become (our) most crippling cost."

Myth: 7. The tort reform package proposed in Massachusetts is a unique and dangerous experiment.

Fact: Again, quoting Time Magazine, "Bills have been introduced or passed in all 50 state legislatures to limit liability awards or regulate insurance or both." California's cap on awards for non-economic losses such as pain and suffering and its regulation of attorney contingent fees has passed Constitutional examination at both the State and Federal Court level. Due to the very escalating nature of the insurance premium crisis, these reforms have not been able to turn back the hands of time to an era of lower, more affordable rates. However, when compared to states such as New York where there is no such cap on non-economic damages and regulation of contingent fees, these reforms have resulted in a marked decrease in the rates of these premium increases.

The California experience points out that reforms of the type proposed in Massachusetts do not destroy the tort system or decrease the amounts paid to injured patients overall. The reform will however, have the important effect of reducing the rate of increase in professional liability premiums paid by health care providers.

There is a growing consensus that serious dislocations in the liability insurance industry are largely a product of excesses in the common law tort system. Recognition of the full scope of the problem is a necessary step towards its solution.

Barbara A. Rockett, M.D.

Editor's Note: Barbara A. Rockett, M.D., is president of the Massachusetts Medical Society.

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Notes & Quotes of Interest

Medline Searches Soon to be Available Through The Springfield Academy of Medicine

In September the Springfield Academy of Medicine will be offering the services of MEDLARS (NLM's Medical Literature Analysis and Retrieval System) to all members of HDMS, as well as non-members.

In July, Margaret Stoler, Library Director, will be attending a five day online database training course for medical librarians offered by the NLM at Dartmouth College in Hanover, New Hampshire. Only upon completion of the course can a librarian qualify for subscription to MEDLARS.

MEDLARS provides access to Medline, a general medical database which contains over 650,000 current files spanning a two year period and over one million files dating back to 1966 for those who want an extended search. The cost for a current Medline search will be \$5.00 for HDMS members and \$15.00 for non-members.

MEDLARS also offers access to other databases such as Toxline (Toxicology) which has a database containing over 500,000 sources, PDQ (Cancer treatment) which has 670,000 sources of reference, and Health Planning Administration which carries 290,000 sources. These databases, as well as numerous others, sponsored by MEDLARS, carry charges that vary according to the database. Charges for entering Toxline is \$75.00 an hour. Rarely would a search require an hour online time. If a member requests search on one of these

databases, the cost would be passed on to the requesting member. An additional charge of \$10.00 would be required of non-members.

The library will be open throughout the summer from 9 a.m. to 4 p.m. Monday through Friday to fulfill any of your medical literature needs.

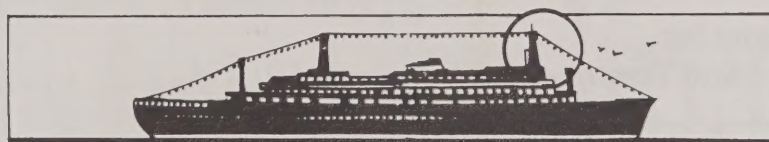
California Doctor Seeks Surplus Medical Books

Los Angeles, CA—Following a trip to China in 1979 where he visited hospitals, medical institutions and met with Chinese doctors, Doctor Jordan M. Phillips, a retired physician, has created at his own expense a non-profit corporation, "Medical Books For China"

While in China he learned that during the reign of the Red Guards, they went on a rampage to stamp out all western culture. Their activities included destroying libraries and burning all medical books. Only a few volumes were saved by brave doctors who hid books and journals in caves.

During the past seven years Doctor Phillips and his wife, Mary, have made 25 trips to China and have arranged for some 700,000 medical books and journals as well as audio tapes, film and slide lectures to be sent to the Chinese doctors.

The Chinese government has established a distribution committee headed by the Health Bureau and the Medical



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School at Tianjin and it is charged with the responsibility of overseeing fair distribution of the medical/educational materials.

The freight costs from Long Beach, California are paid for by the Chinese government and shipment from Tianjin is borne by the doctors and medical institutions who order materials through pre-order forms.

Doctor Phillips is appealing for additional support from the United States medical community for more books, journals and teaching materials.

Medical books should not be older than 1960 and journals no older than 1969.

Medical books, journals, audio tapes, films and slide lectures can be donated to "Medical Books for China". Such donations are 100% tax deductible at current market value. It is suggested that a local medical book store be contacted to establish current value.

Local post offices also can provide information on favorable rates for shipping materials to Doctor Phillips.

Shipments should be made to:

"Medical Books for China"
c/o Dr. Jordan M. Phillips
13021 East Florence Avenue
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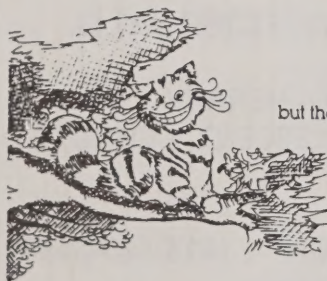
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*Community Caring***Visiting Nurse Association of Springfield
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A diagnosis of dementia of the Alzheimer's type (DAT) usually means a long, sad journey for all of those directly affected: into oblivion and loss of independence for the primary victim and into physical and emotional exhaustion, with financial depletion, for the family. It has been said that no other disease affects a family so deeply. Those among us whose loved ones have been afflicted feel the wounds, and the fear, acutely; families as yet unaffected are rarely aware of the devastating impact of this disease.

With the prediction that, unless halted, DAT will eventually affect one in three families, efforts to increase and coordinate research and to aid those currently afflicted have been intensified — but are threatened by cut-backs at the federal level. The issues are numerous and complex and the ramifications are far-reaching. Who cares for the victims of this dreadful disease goes beyond family and filial responsibility and the burden should be shared by the community.

In 1983 a generous donation from the family of a community leader afflicted by Alzheimer's Disease enabled the Visiting Nurse Association of Springfield (VNAS) to pioneer in providing information and education to the community and emotional support to families affected. Since then the United Way of Pioneer Valley has demonstrated, through grants, the concern of a caring community and services have expanded with the addition of a position of a full-time Coordinator of Alzheimer's Disease and Related Disorders Service (ADRDS). The goals of the program are to provide the services of information and referral, education to the lay and professional communities, and support, advocacy and respite to those persons caring for a loved one afflicted by DAT.

To help with community education the Zonta Club of Springfield demonstrated concern through the donation of funds to produce a unique audio-visual aid. The slide tape presentation features local families and professionals and describes the VNAS program. Further community support has been evident in the work of an advisory committee to the program with representatives from the medical and legal professions, the clergy, the media, nursing home administration, elder service providers and family members. This group strongly supported the concept of aiding research through tissue donation and today families in the Greater Springfield area can arrange to contribute post-mortem brain tissue to research. The VNAS coordinates the Dementia Brain Doion Program which is a cooperative venture with the Baystate Medical Center and the University of Massachusetts Medical Center. Area funeral directors contribute to the smooth running of this facet of ADRDS.

Trained volunteers currently give their time and demonstrate concern by providing respite for family caregivers. Relief from the often 24-hour demands of caring for a demented family member will soon be available in another dimension.

The VNAS is to offer week-end respite to family caregivers through a demonstration project, WEEKEND AWAY, funded by a grant from the Department of Elder Affairs. Specially trained Respite Aides will be placed, under supervision, in the homes of victims of DAT to allow family caregivers the opportunity to regain their energy and perspective.

With the exception of the respite project, which will be available on a sliding fee scale, all services of the VNAS Alzheimer's program are provided at no cost. While there is no cure for DAT we, as a community, must cope with its consequences. The VNAS will continue to provide information and referral, education, support and respite and continue to contribute to finding the cure by promoting research. This effort is made possible by the moral and financial support of a caring community.

Wenda Restall
Coordinator, Alzheimer's Disease and Related Disorders Services

Welcome New Members

Alan S. Brown, M.D.
780 Chestnut St.
Springfield, MA 01107

BORN: September 9, 1951
PREMED: Union College, Schenectady, NY 1969-71
Clark University, Worcester 1971-73
MEDICAL: Brown University 1973-78
INTERNSHIP: Montefiore Hospital, Bronx 1978-79
RESIDENCY: Montefiore Hospital 1979-80 and Albany
Medical Center 1980-83
FELLOWSHIP: Mass. General Hospital, Boston, MA
7/83-12/86
SPECIALTY: RADIOLOGY

Devon C. Foulks, M.D.
155 Maple St.
Springfield, MA 01107

BORN: August 12, 1951
PREMED: Atlantic Union College, Lancaster, MA
1971-75
MEDICAL: Howard University Medical School,
Washington D.C. 1975-79
INTERNSHIP: Howard University Hospital, Washington
1979-80
RESIDENCY: Howard University Hospital, Washington
1980-84
SPECIALTY: OBSTETRICS/GYNECOLOGY

Michael P. Coppola, M.D.
2150 Main St.
Springfield, MA 01104

BORN: September 29, 1952
PREMED: Fordham College, Fordham University
Bronx, NY 1970-74
MEDICAL: Georgetown University School of Medicine
1974-78
INTERNSHIP: State University NY-Upstate Medical
Center, Syracuse, NY 1978-79
RESIDENCY: Georgetown University Hospital,
Washington, DC 1983-85
SPECIALTY: PULMONARY DISEASES

George L. Braden, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN: January 2, 1950
PREMED: University of Cincinnati 1968-72
MEDICAL: Ohio State University School of Medicine
1972-75
INTERNSHIP: University of Michigan 1975-76
RESIDENCY: University of Michigan 1976-78
FELLOWSHIP: Hospital of University of Pennsylvania
1978-81
SPECIALTY: NEPHROLOGY

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Michael E. Scovner, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN: October 29, 1957
PREMED: Dartmouth College 1975-78
MEDICAL: Ohio State University 1979-84
INTERNSHIP: Baystate Medical Center 1984-85
RESIDENCY: Baystate Medical Center 1985-present
SPECIALTY: PEDIATRICS

Christopher O'Reilly-Green, M.D.
759 Chestnut St.
Springfield, MA 01107
RESIDENT

BORN: July 4, 1946
PREMED: MIT, Cambridge, MA 1965-72
MEDICAL: St. Louis University 1970-78
INTERNSHIP: University of Hawaii, 1978-79
RESIDENCY: Carney Hospital 1981-82
University of Hawaii 1982-84, Baystate
Medical Center 1985-present
SPECIALTY: OB/GYN

Steven L. Cooper, M.D.
759 Chestnut St.
Springfield, MA 01107
BORN: August 16, 1957
PREMED: Brandeis University, Waltham 8/75-5/79
MEDICAL: University of Miami School of Medicine,
Miami, Florida 1980-84
INTERNSHIP: Baystate Medical Center 1984-85
RESIDENCY: Baystate Medical Center 1985-Present
SPECIALTY: PEDIATRICS

Gary F. Rockwell, M.D.
759 Chestnut St.
Springfield, MA 01107
BORN: June 4, 1949
PREMED: PENN STATE 1967-71
MEDICAL: University of Rochester, 1971-75
INTERNSHIP: University of Hospitals of Cleveland 1975-76
RESIDENCY: University of Hospitals of Cleveland 1976-78
FELLOWSHIP: LAC/USC, Los Angeles, 1978-80
SPECIALTY: PEDIATRICS, NEONATAL-PERINATAL

Daniel R. Fishbein, M.D.
1295 State St.
Springfield, AM 01111

BORN: June 13, 1961
PREMED: Boston University, Boston 1979-81
MEDICAL: Boston University, Boston, 1981-85
SPECIALTY: ADMINISTRATIVE (MASS. MUTUAL)

Joanne M. Bessette, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN: July 18, 1950
PREMED: Smith College, Northampton, MA 1968-72
MEDICAL: Tufts University School of Medicine
1972-76
INTERNSHIP: St. Elizabeth's Hospital 1976-77
RESIDENCY: St. Elizabeth Hospital 1977-79
FELLOWSHIP: New England Medical Center 1979-84
SPECIALTY: ONCOLOGY/HEMATOLOGY

Mark A. Hirschhorn, M.D.
444 Montgomery St.
Chicopee, MA 01020

BORN: February 26, 1951
PREMED: Case Western Reserve University 1969-73
MEDICAL: New York University School of Medicine,
1973-77
INTERNSHIP: Baltimore City Hospital 1977-78
RESIDENCY: Baltimore City Hospitals 1978-81
Greater Baltimore Medical Center 1980-81
FELLOWSHIP: SUNY Upstate Medical Center 1981-83
SPECIALTY: GASTROENTEROLOGY

Lura D. Winstead Stagg, M.D.
123 Dwight Road
Longmeadow, MA 01106

BORN: February 21, 1942
PREMED: University North Carolina, Greensboro
1960-64
MEDICAL: Bowman Gray School of Medicine 1964-68
INTERNSHIP: St. Francis Hospital, Hartford, 1968-69
RESIDENCY: St. Francis Hospital, Hartford, 1969-71
SPECIALTY: PEDIATRICS/ADULT MEDICINE

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In Memoriam

SALVATORE SANNELLA, M.D.

Salvatore Sannella, died April 10, 1986 at age 97. Born in Italy, he graduated from American International College and Springfield College. In 1918, he graduated from Tufts Medical School and promptly became the lone intern at Springfield Hospital during the influenza epidemic.



DR. SANNELLA AND HIS WIFE
SUSAN PICTURED AT A 1985
HDMS MEETING.

In addition to his busy Springfield practice which spanned over 60 years, he was active in academic, civic, and professional affairs. He was honored by all three schools from which he graduated and established scholarships at each. Tufts honored him a few years ago with an award for his "exemplary service to human kind as an outstanding general practitioner."

He and his wife Susan attended District Society meetings until very recently and enjoyed concerts and dinners regularly. In addition to his wife, he leaves a son, a daughter, a brother, seven grandchildren and 16 great-grandchildren.

LULU H. WARNER, M.D.

Lulu H. Warner died May 3, 1986 at age 75. She was the retired chief of the Holyoke Hospital Anesthesiology Department, and was the first woman to serve as President of that hospital's medical staff. A native of Amherst, she was a graduate of the University of Massachusetts and Tufts University Medical School. She is survived by a step-brother and a step-sister.

JOSEPH P. DERBY, M.D.

Joseph P. Derby died April 15, 1986 at age 92. He maintained an orthopedic practice in Springfield for more than 50 years. He graduated from Catholic University of America and Harvard Medical School, with his orthopedic residency at Worcester City, Boston Children's and Mass General Hospitals. Among his many professional and civic interests was the Springfield Lodge of Elks which gave him a lifetime achievement award in 1976.

He was a past President and Chief of Staff at Mercy Hospital. He was also a past President of HDMS and the Springfield Academy of Medicine as well.

He leaves his wife, Alberta, two sons, two daughters, two sisters, 13 grandchildren and two great grandchildren.

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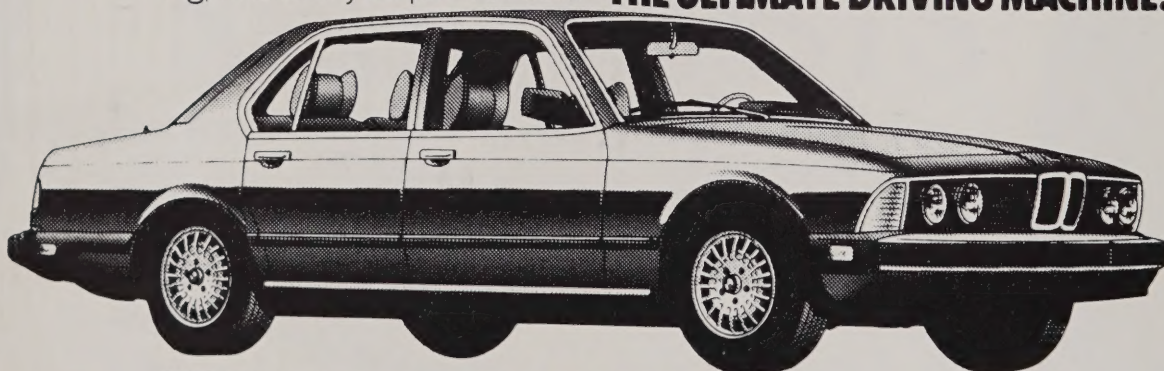
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